

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/19/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CIT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 W HOMER ST MICHIGAN CITY, IN 46360</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00135110</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 12/19/13</p> <p>Facility Number: 005015</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Franciscan St. Anthony Health - Michigan City is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 01/03/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE